C.K. Matsuno PT

PhysioComplex

Patient Questionnaire

(This information is kept confidential)

Patient Name: _____Today's Date: _____
Gender: _____Age:_____DOB:_____
Physician: _____
Address: _____
Phone Number: _____
Email: _____

Whom did you hear about us?

_____

History of current condition:

_____
_____
_____

Any special tests that have been performed, the body part tested and the results (X-ray, MRI, CT scan)?

_____
_____
_____

Have you had any Tooth or Gum issues? (Root Canals, Gum Infections, Dental Implants etc.)

_____
_____
_____

Are you taking Cholesterol Lowering Statins or Blood Pressure Meds? (Lipitor, Zocor, Crestor etc.) Dosage? How Long?

_____
_____
_____

Have you had any other treatments for your current condition? (e.i., PT, Chiropractic, Massage, Acupuncture) Please list practitioners.

_____
_____
_____

What has had a positive effect?

_____
_____
_____

What has had a negative effect?

_____
_____
_____

Have you been advised to have any surgery that has not been done?

_____

Please list **all** previous injuries, accidents, and any other pertinent medical information.

_____
_____
_____

Please list **all** medical conditions and/or health concerns.

_____
_____
_____

Please list **all** current medications and vitamins:

_____
_____
_____

Please list **all** allergies:

_____
_____

Any previous surgeries? (Please note the year)

_____
_____
_____
_____

Do you have or have you had any of these symptoms in the past year?
(Check all that apply)

Headache/Migraines_____ Persistent joint pain _____
Change in bowel _____Irritable bowel _____ Blood in bowel/urine _____
Vertigo or Dizziness _____ Persistent nose bleeds _____
Difficulty concentrating _____ Learning disabilities _____
Tiredness/Fatigue _____ Muscle Spasms _____
Fainting spells _____ Eating Disorder/Difficulty _____Difficulty Sleeping _____
Sleep Apnea_____CPAP Machine _____
Other:_____
_____

Any history of: (Check all that apply)

Head or Spinal injuries _____Recurrent headaches _____ Meningitis _____
Stomach Ulcers _____ Heartburn/Indigestion _____ Shortness of breath _____
Have you ever been rendered Unconscious?_____Concussions?_____

Dental History: (Please elaborate when possible)
Who is your Dentist? _____
Previous braces? _____ Ever wear a retainer?_____
Grind or Clench your teeth?_____
Ever wear a dental splint?_____Currently using a night guard?_____
TMJ Disorder_____
Popping or clicking in jaw? _____Jaw ever lock_ _____
Other:
_____

Please describe your own birth (Forceps, Natural, C-Section) _____
Any complications with your birth?
_____
_____

For Women Only:
Please list number of: _____Pregnancies _____Children
Date of last pelvic exam: _____
Date of last pap smear test: _____ Negative or Positive: _____

Please check all that apply:
_____ Menstrual cycle irregular _____ Pass blood clots
_____ Pain and cramping during period
_____ Taking birth control? How Long? _____

Any other information about pregnancies, complications with delivery, or menstrual problems?
_____
_____

Menopausal Symptoms:
Hot Flashes _____ Night Sweats _____
Hormone Replacement Therapy _____
Type(s) of Hormones Taken _____

Any additional information you would like to provide?
_____
_____
_____
_____